

INITIAL \_\_\_\_\_

## ROSE FAMILY Early Childhood Education Center 14200 Lamar Avenue • Overland Park, Kansas 66223 • www.bethshalomkc.org School (913) 647-7285 • Synagogue (913) 647-7279 • Fax (913) 647-7278



EMERGENCY INFORMATION (Please fill out as completely as possible)	TODAYS DATE:
CHILD'S NAME	DATE OF BIRTH WEIGHT
HEBREW NAME	NICKNAME
NAME FOR CUBBIES	
ALLERGIES	
WHAT IS THE REACTION?	
PARENT 1 NAME	PARENT 2 NAME
HEBREW NAME	HEBREW NAME
HOME ADDRESS	HOME ADDRESS
CELL PHONE	CELL PHONE
E-MAIL ADDRESS	E-MAIL ADDRESS
PLACE OF EMPLOYMENT	PLACE OF EMPLOYMENT
PHONE	PHONE
OCCUPATION/TITLE	OCCUPATION/TITLE
PEDIATRICIAN'S NAME	PHONE
ADDRESS	
HOSPITAL PREFERENCE	
IN CASE OF AN EMERGENCY (PARENTS WILL BE NOTIFIED BESIDE YOURSELVES (PLEASE CONTACT THE SCHOOL OF	D FIRST), PLEASE LIST EMERGENCY CONTACTS WE CAN REACH FFICE IMMEDIATELY WITH ANY CHANGES):
1)	HOME PHONE
RELATIONSHIP	CELL PHONE #
2)	HOME PHONE
RELATIONSHIP	CELL PHONE #
3)	HOME PHONE
RELATIONSHIP	CELL PHONE #



### ROSE FAMILY Early Childhood Education Center 14200 Lamar Avenue • Overland Park, Kansas 66223 • www.bethshalomkc.org School (913) 647-7285 • Synagogue (913) 647-7279 • Fax (913) 647-7278



# STUDENT INFORMATION SHEET

CHILD'S NAME	
ARE THERE ANY PHYSICAL PROBLEMS OR LIMITATIONS WE SHOULD KNOW ABOUT?	К
DOES YOUR CHILD TAKE ANY MEDICATIONS REGULARLY? IF SO, PLEASE LIST THE NAME(S), THE DOSE, AI REASON FOR THE MEDICATION.	ND THE
HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES IN THE PAST?	
PLEASE LIST CONTAGIOUS DISEASES AND DATES	
HAS YOUR CHILD EVER BEEN HOSPITALIZED? WHEN? FOR HOW LONG? FOR WHAT?	
BROTHERS AND SISTERS:  NAME BIRTHDATE SCHOOL ATTENDING	
WHAT WOULD YOU LIKE YOUR CHILD TO GET OUT OF THIS YEAR'S SCHOOL EXPERIENCE?	

DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S SCHOOL EXPERIENCE?						
WHAT ARE YOUR CHILD'S FEARS?HOW DOES HE/SHE REACT TO THEM?						
HOW DO YOU COMFORT YOUR CHILD?						
HOW DO YOU DISCIPLINE YOUR CHILD?						
DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S SPEECH AND LANGUAGE DEVELOPMENT?						
DO YOU HAVE ANY CONCERNS ABOUT YOUR CHILD'S MOTOR DEVELOPMENT?						
HAS YOUR CHILD EVER HAD A SPEECH & LANGUAGE, MOTOR OR BEHAVIORAL EVALUATTION? YESNO IF ANSWER IS YES, BY WHAT AGENCY AND DOES YOUR CHILD RECEIVE THERAPY?						
IS THERE ANY INFORMATION THAT WE SHOULD HAVE TO BE MORE EFFECTIVE WITH YOUR CHILD? HOW CAN WE BE OF THE MOST HELP TO YOU?						
ANY OTHER ADDITIONAL CONCERNS?						



#### ROSE FAMILY Early Childhood Education Center 14200 Lamar Avenue • Overland Park, Kansas 66223 • www.bethshalomkc.org School (913) 647-7285 • Synagogue (913) 647-7279 • Fax (913) 647-7278



# **NEW STUDENT INFORMATION SHEET**

Child's Name
Parents Names
Were there any concerns at birth?
When did your child first sit up?
When did your child first crawl?
When did your child first walk?
First Words?
What were they?
Does your child speak in complete sentences?
What language do you speak at home?
Other than Beth Shalom, are there any previous Nursery School, camp or day care experiences your child has had? If so, where and how long? Was it a positive experience?

Has your	child been left w			No. How often?_
Anything	special or conce	rns we should	know about yo	our child?



#### ROSE FAMILY Early Childhood Education Center 14200 Lamar Avenue • Overland Park, Kansas 66223 • www.bethshalomkc.org School (913) 647-7285 • Synagogue (913) 647-7279 • Fax (913) 647-7278



# Toddler, Mini-School & 3's Questionnaire

Child's Name			
Can your child have juice?	Yes _	No	
Do you dilute the juice?	Yes _	No	
Can your child have popcorn?	Yes _	No	
Can your child have raw carrots?	Yes _	No	
Can your child have raw celery?	Yes _	No	
Can your child have cucumbers?	Yes _	No	
*We serve 2% milk with snacks. <i>If you would like y</i> this, you will need to supply it.* Please let the tea  What raw fruits does your child eat?	acher know.*		ın
What are your child's favorite foods?			
Is your child toilet trained?YesIf not, are they inDiapersI  Terminology used to express toileting needs	No ⊃ull-ups		
Does your child have a security item?  What is it?  What does your child call it?	Yes _	No	
Does your child use apacifier,l  Please make sure your child has this/these items  s there anything else you would like us to know?			

Please update our staff or the director as this information changes.

CCL 010 Rev. 2/2010 Kansas Department of Health and Environment

Child Care Licensing and Registration Program

1000 SW Jackson, Suite 200 Topeka, KS 66612-1274

Phone: (785)296-1270 Fax: (785)296-0803

Website: www.kdheks.gov/kidsnet



#### **AUTHORIZATION FOR EMERGENCY MEDICAL CARE**

Written permission for emergency medical treatment must be on file at the facility. Consult with the local emergency medical facility to be sure this form is acceptable. Reference K.A.R. 28-4-127(b)(1)(A) except School Age Programs reference K.A.R. 28-4-582(e)(2)(B).

(Name of individual/staff member) who is (are) representative(s) pove named facility to give consent for any and all necessary emergency medical care for my child or youth	Name of facility exactly as stated on the license/certificat Beth Shalom Early Childhood Educat	License or Certificate #	
Date Signed  Country of Signed or attested before me on	hereby authorize Beth Shalom	(Na	ame of individual/staff member) and/or
Core named facility to give consent for any and all necessary emergency medical care for my child or youth  (First and Last Name of Child or Youth) while said child or youth is in said to instody between the dates of beat named of Care and Care terminated MM/DD/YYY  Signature of Parent or Guardian  Date Signed  Witness to Parent's or Guardian's signature only if required by the local hospital or clinic.  State of Kansas  County of	Director/Staff	(Name of individual/staff me	mber) who is (are) representative(s) of th
Signature of Parent's or Guardian  Witness to Parent's or Guardian's signature only if required by the local hospital or clinic.  State of Kansas  County of	bove named facility to give consent for any and all necessary	emergency medical care for my	child or youth
Witness to Parent's or Guardian's signature only if required by the local hospital or clinic.  Date Signed  County of	istody between the dates of beginning of care	and care termin	949
charization of Parent's or Guardian's signature  State of Kansas  County of  Signed or attested before me on by	Signature of Parent or Guardian		Date Signed
State of Kansas  County of	Witness to Parent's or Guardian's signature only if requir clinic.	red by the local hospital or	Date Signed
County of	otarization of Parent's or Guardian's signature		•
Signed or attested before me on	State of Kansas		192
MM/DD/YYYY Name of Person  Signature of notarial officer  Title (and Rank) My appointment expires:  Implete information regarding health care insurance, if applicable.  Health Insurance Policy Name:  Medical Assistance Program  Military Medical Care J.D. Number  Known, date of last Tetanus inoculation:	County of	8	
Signature of notarial officer  Title (and Rank) My appointment expires:  Implete information regarding health care insurance, if applicable.  Health Insurance Policy Name:  Medical Assistance Program  Military Medical Care I.D. Number  Known, date of last Tetanus inoculation:	Signed or attested before me on	by	
Signature of notarial officer  Title (and Rank)  My appointment expires:  Implete information regarding health care insurance, if applicable.  Health Insurance Policy Name:  Medical Assistance Program  Military Medical Care I.D. Number  Known, date of last Tetanus inoculation:	MM/DD/YYYY	Name of Per	son
Title (and Rank)  My appointment expires:  Implete information regarding health care insurance, if applicable.  Health Insurance Policy Name:  Medical Assistance Program  Military Medical Care I.D. Number  Known, date of last Tetanus inoculation:	(Seal, if any.)	*	
My appointment expires:		Signature of notarial offi	icer
mplete information regarding health care insurance, if applicable.  Health Insurance Policy Name: Policy Number Card Number		Title (and Rank)	
Health Insurance Policy Name: Policy Number   Medical Assistance Program Card Number   Military Medical Care I.D. Number Card Number   Known, date of last Tetanus inoculation:		My appointment expires	×
Health Insurance Policy Name: Policy Number   Medical Assistance Program Card Number   Military Medical Care I.D. Number Card Number   Known, date of last Tetanus inoculation:	omplete information regarding health care insurance, if a	applicable.	
Medical Assistance Program Card Number Military Medical Care I.D. Number known, date of last Tetanus inoculation:			olicy Number
Military Medical Care I.D. Number			Card Number
at any known allergies or other information about the medical status of this child or youth pertinent in case of emergence			

THE MEDICAL RECORD/ASSESSMENT FORM (OR HEALTH STATUS HISTORY FORM FOR SCHOOL AGE PROGRAMS) AND THE AUTHORIZATION FOR EMERGENCY MEDICAL CARE MUST BE TAKEN TO THE EMERGENCY ROOM. BOTH FORMS MUST ALSO BE IN A VEHICLE WHEN THE CHILD OR YOUTH IS TRANSPORTED BY THE FACILITY.

CCL. 029 Rev. 8/2011

#### Kansas Department of Health and Environment

Bureau of Child Care and Health Facilities Child Care Licensing Program 1000 SW Jackson, Suite 200 Topeka, KS 66612-1274 Phone (785) 296-1270 Fax (785) 296-0803

Website: www.kdheks.gov/kidsnet



MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES, INCLUDING PROVIDER'S OWN CHILDREN

Parents are to complete the Medical Record and the History of Immunizations for each child in licensed child care facilities. The Medical Record, History of Immunizations, and Child Health Assessment are transferable when the child moves to another licensed child care facility.

Child's First Day in Child Care			Name of Child Care Facility					
Child's Name			Date of Birth			Gender		
-	First	Last			MM/DD/Y	YYY	M/F	
Parent/Guardian Information			Parent/Guardian Information					
Name				Name				
Home Address_				Home Address				
	Street	City	Zip Code	St	reet	City	Zip Code	
Home Phone Nu	ımber			Home Phone Num	ber			
Work Address				Work Address				
	Street	City	Zip Code		reet	City	•	
Work Phone Nur	mber			Work Phone Numb	er			
Cell Phone Num	ber		<u>-</u>	Cell Phone Number	r,			
E-mail Address				E-mail Address				
Best way to con	tact			Best way to contact	ct			
Names and ages	s of children in t	family						
Persons authoriz	ed to pick up t	ne child or to no	tify in case of	emergency. Include	name, ad	dress, and te		
Child's Physician				Phone Number				
Child's Dentist_				Phone Number				
Hospital Prefere	nce (for emerge	encies)						
				medications for you ler?NoYe			ophen, cough	
Emergency MediAllergiAsthmEpilep	ical Care form ( es a sy/Seizures	CCL. 010.	Frequent sore Speech, Visual Other	, Hearing	nformation - -	on Authoriza Ear A Diabe	ches	
If yes answered	to any above, p	olease provide a	dditional infor	mation				
Have there been	major changes	at home that m	night affect yo	ur child in care?	No	res, as follow	s:	
Please provide a	dditional inform	nation or special	instructions th	nat will help the pers	on caring f	or your child		
Parent/Guardi	an Signature:				D	ate:		

CCL. 029a Rev. 08/2011

#### **Child Health Assessment**

The Child Health Assessment form is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

A Child Health Assessment, recorded on a KDHE Form or other acceptable Forms mentioned below, is required for all children including children of the provider or staff in Licensed Day Care Homes, Group Day Care Homes, Child Care Centers and Preschools. A Kan-Be-Healthy Assessment Form is a KDHE Form and is acceptable, a Physician Health Assessment Form is acceptable for school-age children or youth. The Health Assessment Form used should be attached to the KDHE Medical Record Form (CCL. 029).

Child's Name		Da	e of Birth		
First	La	st			
Health history and medical information p (describe, if any):	ertinent to routine ch	nild care and emergencies	Do you see this child for regular health supervision:		
☐ None			☐ Yes ☐ No		
Allergies to food or medicine (describe, if	f any):				
None					
List current medications (if any):					
None					
Length/Height:IN/CM %	oILE	Weight: LB/KB	%ILE		
Physical Examination	✓ If Normal	If Abnormal - Commen			
Head/Ears/Eyes/Nose/Throat					
Teeth					
Cardio/Respiratory					
Abdomen/GI					
Genitalia/Breasts					
Extremities/Joints/Back/Chest					
Skin/Lymph Nodes		1			
Neurologic & Developmental					
Screening Tests	Screening Date	Note Here if Results ar	e Pending or Abnormal		
Lead					
Anemia (HGB/HCT)					
Urinalysis (UA)					
Hearing					
Vision					
Health Problems or Special Needs, Recon	nmended Treatment/	  Medications/Special Care (A	ttach additional sheets if necessary)		
None			,,		
Signature of Licensed Physician or Nurse	approved for Child H	lealth Assessments	Date		
Print the Name of the Individual Signing	Above		Phone Number		
Address		City	Zip Code		

### **History of Immunizations**

\_\_\_\_\_Date of Birth: \_\_\_\_\_

Required for all children in child care facilities, including the provider's own children. A Kansas Certificate of
Immunizations (KCI) may be substituted for this form and attached to the completed Medical Record.

Child's Name:\_\_\_

Vaccine	Recoi	rd the Month	. Day and Yea	r that each Dose of	Vaccine was	Received
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>	6 <sup>th</sup>
<b>DTaP/DT/Td/Tdap</b> (Diphtheria, Tetanus, Pertussis)						
Polio					E TOTAL	7-1198
MMR (Measles, Mumps, and Rubella combined)						
HBV (Hepatitis B Vaccine)						
Varicella (Chicken Pox)			Hx of Disea Physician S		Date of	Illness:
HIB (Hemophilus Influenzae Type B)						Can Marie
PCV7 (Pneumococcal Conjugate)						
HEP A (Hepatitis A)						
Rotavirus **Recommended <8 mo of age; not required						
Influenza(Flu) ** Recommended annually >6 mo of age; not required						
The following two options are the complete as required:	e ONLY exemp	otions allowe	d by law. Ple	ase check either (	(A) or (B) be	low and
Complete this section only if your The following two options are the	e ONLY exemp	otions allowed	d by law. Ple	ase check either (	(A) or (B) be	low and
The following two options are the complete as required:  (A) Certification from licer Exempt from following immunization.	e ONLY exemp	otions allowed	d by law. Ple	ase check either (	(A) or (B) be	low and
The following two options are the complete as required:  (A) Certification from licent Exempt from following immunization.  DTPPertussis Only	e ONLY exemposed physicial tions:	ntions allower  nn stating ti	d by law. Pleanat immuniza	ase check either ( ation would enda	(A) or (B) be	low and
The following two options are the complete as required:  (A) Certification from licent Exempt from following immunization.  DTPPertussis Only HibPCV7Other	e ONLY exemple on the original of the law from the law fr	n stating ti	d by law. Plea	ase check either ( ation would enda Rubella Only	A) or (B) beinger child's  Hep A  Date:	low and life:Hep
The following two options are the complete as required:  (A) Certification from liced Exempt from following immunization.  DTP Pertussis Only Hib PCV7 Other  Physician's Signature (required)  (B) My child is exempt under the complete this section only in the complete this section only if yellowing two options are the complete this section only if yellowing two options are the complete this section only if yellowing two options are the complete this section only if yellowing two options are the complete this section only if yellowing two options are the complete this section only if yellowing two options are the complete this section only if yellowing two options are the complete this section only if yellowing two options are the complete as required:	e ONLY exemple on the original of the law from the law fr	n stating ti	d by law. Plea	ase check either ( ation would enda Rubella Only	A) or (B) beinger child's  Hep A  Date:	low and life:Hep

CCL. 035 Rev. 3/2017

Kansas Department of Health and Environment
Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: (785) 296-1270 Fax: (785) 559-4244
Website: www.kdheks.gov/kidsnet



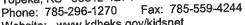
### PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS **GROUP OF CHILDREN TO ONE LOCATION**

Beth Shalom Early Child	ense)	nler		Licens	e# 7829-	017
Street Address of Facility	City	71101	Zip Code	C	ounty	012
14200 Lamar AVP	City O. P.				Johnso	N
Children or Youth listed below may go on an c	off_nremice trin	to Ever	edom	13/1	nV	
Located at: 6640 W 14374 S	t. Overl	and Par	K,KS	J	phnson	
Located at: 6640 W 143rd Son AS Needed In Case of EMER (MM/DD/YYYY)	rgency.	City		Co	unty	
Time of Departure:	_ Estimated	Time of Ret	urn:			_
Children or Youth will be traveling by:	Veh	nicle <u></u>	< w	alking		
Children or Youth will be supervised at all time		-				
staff Name Judy Jacks Bermal	<u> </u>	Staff Name	_Deb	bie	Bezno	VSKY
Staff Name Melisa Gum	ast	Staff Name	First		Last	
First La	ast		First		Last	
FIRST AND LAST NAME OF CHILD OR YO	оитн				NATURE GR	
		LINING	orum priore	iuue i i	ist and Last	(Name)
						3

CCL. 034 Rev. 3/2017

# Kansas Department of Health and Environment

Bureau of Family Health
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone: 785-296-1270
Fax



Website: www.kdheks.gov/kidsnet



# PARENTAL PERMISSION FORM FOR OFF-PREMISES TRIPS

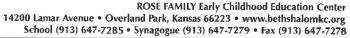
lame of the Facility (exactly as state	d on the license)			ense #	
Seth Shadom Early state State Shadom Early Street Address of the Facility 14200 Lamar Ave.	cilliand Cente	N.	b	05782	9-012
beth Shalom Early	City	71	Zip Code	County	, , ,
treet Address of the Facility	City	10.41	1.1222	1. John	Nazi
4200 Lamar Ave.	over and	1 Park	06220	00/1/	700-1
First and Last Name of Child or	may go to the follow				
First and Last Hame of State		City	By	/ Vehicle	(Walk/Bike
ace foldsmith Hall	Street Address 14200 Lamar Ave.	0.P.			
ignature of Parent or Guardian	71-0		Da	ate Signed	
ignature of t are to the same					
Place :\accido	Street Address	City	В	y Vehicle	Walk Bike
Downstairs Living	14200 Lamar Ave.	0.P.	n	ate Signed	
ignature of Parent or Guardian				210 0191104	
		City	R	y Vehicle	(Walk/Bike
Place	Street Address 14200 Lamar Ave	City O.P.	ا	y voilioio	
Signature of Parent or Guardian	14200 Lanton 1100	101	D	ate Signed	
Signature of Parent of Guarana.					
-	Street Address	City	8	y Vehicle	Walk/Bike
Place				-t- Olamon	
Signature of Parent or Guardian			D	ate Signed	
Place	Street Address	City	E	By Vehicle	Walk/Bike
Fidee				ate Signed	
Signature of Parent or Guardian					
					1 104 17 17 14
Place	Street Address	City		By Vehicle	Walk/Bike
Signature of Parent or Guardian			I	Date Signed	
Place	Street Address	City	-	By Vehicle	Walk/Bike
1 14444	30				
Signature of Parent or Guardian				Date Signed	



# **Over The Counter Medication Permission Form**

We,	
(names of parents)	· · · · · · · · · · · · · · · · · · ·
give permission to the Nursery School	administration and staff
to administer the following OTC medic	
_	sary by the Director or
her assistant. The staff will attempt to	can for your approvar.
Child's Weight:	
Children's Tylenol	Dosage
(Acetaminophen)	
	_
Benadryl	Dosage
	<b>.</b>
Children's Advil (Ibuprofen)	Dosage
Calamine Lotion	
Cunsaraan	
Sunscreen	
Signature	Date







### **PICK UP AUTHORIZATION 2020-21**

No child will be turned over to an adult other than a parent unless we have written authorization from you. Please complete the following authorization, affix your signature and return it to the school as soon as possible. Please make sure this is updated as your arrangements change.

My child	is to go home <b>ONLY</b> with the following family member de cell phone numbers below.
Cell Number	Relationship
ADDITIONAL COMMENTS:	
(Parent's Signature)	(Date)

\*\*Remember: Please send a note if anyone other than your carpool will be taking your child home\*\*

PLEASE CONTACT THE SCHOOL OFFICE IMMEDIATELY IF THERE IS ANY CHANGE IN CARPOOL AUTHORIZATION.



Date \_\_\_\_

# **Payment Options Plan**

Two Payments - 50% due by A	ugust 15, 2020 and the balance by Dec	cember 15, 20
Check or	,	
Credit Card Payment - Process Visa, Mastercard or Discover • MAXIMUM of two payments	sed 15 <sup>th</sup> of every month or next busines s per year will be accepted.	s day
Credit Card #	Expiration Date	cvc_
Automatic Bank Transfer (ABT) Automatically withdrawn from	/ month, August 2019 through April 202 ) - Processed 20 <sup>th</sup> of each month, or ne checking or savings account eck that shows your bank routing an	xt business d
Automatic Bank Transfer (ABT)  Automatically withdrawn from	) - Processed 20 <sup>th</sup> of each month, or ne checking or savings account eck that shows your bank routing an	xt business d
Automatic Bank Transfer (ABT)  Automatically withdrawn from	) - Processed 20 <sup>th</sup> of each month, or ne checking or savings account eck that shows your bank routing an	xt business d
Automatic Bank Transfer (ABT) Automatically withdrawn from Please provide a VOIDED che	) - Processed 20 <sup>th</sup> of each month, or ne checking or savings account eck that shows your bank routing an	xt business d
Automatic Bank Transfer (ABT) Automatically withdrawn from Please provide a VOIDED che	) - Processed 20 <sup>th</sup> of each month, or ne checking or savings account eck that shows your bank routing an	xt business d
Automatic Bank Transfer (ABT) Automatically withdrawn from Please provide a VOIDED che	) - Processed 20 <sup>th</sup> of each month, or ne a checking or savings account eck that shows your bank routing an	xt business d

Printed Name \_\_\_\_\_

Signature